

FIGURE 1

Patient Information

Name	[REDACTED]		
Address	[REDACTED]		
Home Phone	[REDACTED]	Work Phone	[REDACTED]
E-mail	[REDACTED]		
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Birth date	Month	Day	Year
Race/Ethnicity	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/> African American <input type="checkbox"/> Native American	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Multiracial
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Separated	<input type="checkbox"/> Living with another <input type="checkbox"/> Divorced	<input type="checkbox"/> Married <input type="checkbox"/> Widowed
Education Level	<input type="checkbox"/> High school or less <input type="checkbox"/> Graduate degree	<input type="checkbox"/> Vocational/technical <input type="checkbox"/> Professional degree	<input type="checkbox"/> College degree
Occupational Status	<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed	<input type="checkbox"/> Student	<input type="checkbox"/> Retired
Insurance/Billing	1 [REDACTED]	2 [REDACTED]	

FIGURE 2

Patient ID: _____ Age: _____ Sex: _____ Procedure ID: _____ Date: _____

Reason for visit Routine (e.g., checkup) 1st visit to this physician, or new medical condition Follow-up for existing medical condition

Referred by Primary care physician Another specialist Self

Referring diagnosis

ICD-9 codes

Phenomenon category

Lump/bump
 Wrong direction

Discharge/leak
 Discoloration

Bleeding
 Intake difficulty

Other phenomenon category

If you are experiencing a new medical problem, symptom, or condition, please fill out the following:

Chief complaint

Symptom duration

Symptom quantity
(disease-specific)

Symptom timing
(disease-specific)

Symptom context

Symptom quality

Relevant past Hx

Previous consult with another physician Yes No

Received medical treatment for this condition Yes No

Previous surgery for this condition Yes No

Other

Relevant Family Hx
(disease-specific)

If this is a follow-up visit, please answer the following:

Symptom evolution (per symptom) Gone away completely Improved No change
 Worse

FIGURE 3

Patient ID: _____ Age: _____ Sex: _____ Procedure ID: _____ Date: _____

Are you experiencing any of the following problems?	<input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue	Constitutional
Do you have lazy eye?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Eye Problems
Any new vision/eye problems? If yes, please check...	<input type="checkbox"/> Yes <input type="checkbox"/> Blurred vision <input type="checkbox"/> Eye pain	<input type="checkbox"/> No <input type="checkbox"/> Double vision <input type="checkbox"/> Eye redness	<input type="checkbox"/> Loss of vision <input type="checkbox"/> Eye dryness	
Are you having hearing, balance, speech, or throat problems? If yes, please check...	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Ear/Nose/Throat
	<input type="checkbox"/> Trouble hearing <input type="checkbox"/> Loss of balance <input type="checkbox"/> Hoarseness	<input type="checkbox"/> Ringing in ear(s) <input type="checkbox"/> Ear pain <input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Dizziness (vertigo) <input type="checkbox"/> Ear discharge <input type="checkbox"/> Slurred speech	
Have you been told you have a heart murmur?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Cardiovascular
Are you experiencing any chest pain, heart problems, limb pain, or fainting? If yes, please check...	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	<input type="checkbox"/> Chest pain <input type="checkbox"/> Fainting	<input type="checkbox"/> Limb swelling <input type="checkbox"/> Limb pain on walking	<input type="checkbox"/> Fast heart beat <input type="checkbox"/> Irregular heart beat	
Do you have asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Respiratory
Are you having problems breathing, coughing, or coughing up anything? If yes, please check...	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	<input type="checkbox"/> Trouble breathing	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Coughing blood	
Are you having any stomach or digestive problems? If yes, please check...	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Gastrointestinal
	<input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heart burn <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Regurgitation <input type="checkbox"/> Bloody stools	

FIGURE 4

Are you having any problems urinating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please check...	<input type="checkbox"/> Incontinence <input type="checkbox"/> Excessive urination <input type="checkbox"/> Pain on urination <input type="checkbox"/> Blood in urine		
Are you having any muscle or joint problems or pain anywhere?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please check...	<input type="checkbox"/> Joint swelling <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle cramp <input type="checkbox"/> Muscle twitches <input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Loss of muscle		
Are there any changes to your skin, hair, sense of feel, or sweating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please check...	<input type="checkbox"/> Numbness <input type="checkbox"/> Hair loss <input type="checkbox"/> Skin rash <input type="checkbox"/> Tingling <input type="checkbox"/> Nail changes <input type="checkbox"/> Dry eyes/mouth <input type="checkbox"/> Discoloration <input type="checkbox"/> Sweating changes		
Are you having headaches/head pain, blackouts, coordination problems, or memory problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please check...	<input type="checkbox"/> Headache <input type="checkbox"/> Weakness <input type="checkbox"/> Blackouts <input type="checkbox"/> Face pain <input type="checkbox"/> Tremors <input type="checkbox"/> Trouble with memory <input type="checkbox"/> Face numbness <input type="checkbox"/> Clumsiness <input type="checkbox"/> Trouble concentrating		
Are you having any psychological issues or problems with sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please check...	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Feeling depressed <input type="checkbox"/> Inappropriate crying <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Inappropriate laughing		
Are you bleeding or have found any lumps/swelling that are new?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Lumps or swellings		
Do you have any of the other following symptoms?	<input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heat/cold intolerance		

Genitourinary

Musculoskeletal

Skin & Breast

Neurologic

Psychiatric

**Hematologic/
lymphatic**

Endocrine

FIGURE 5

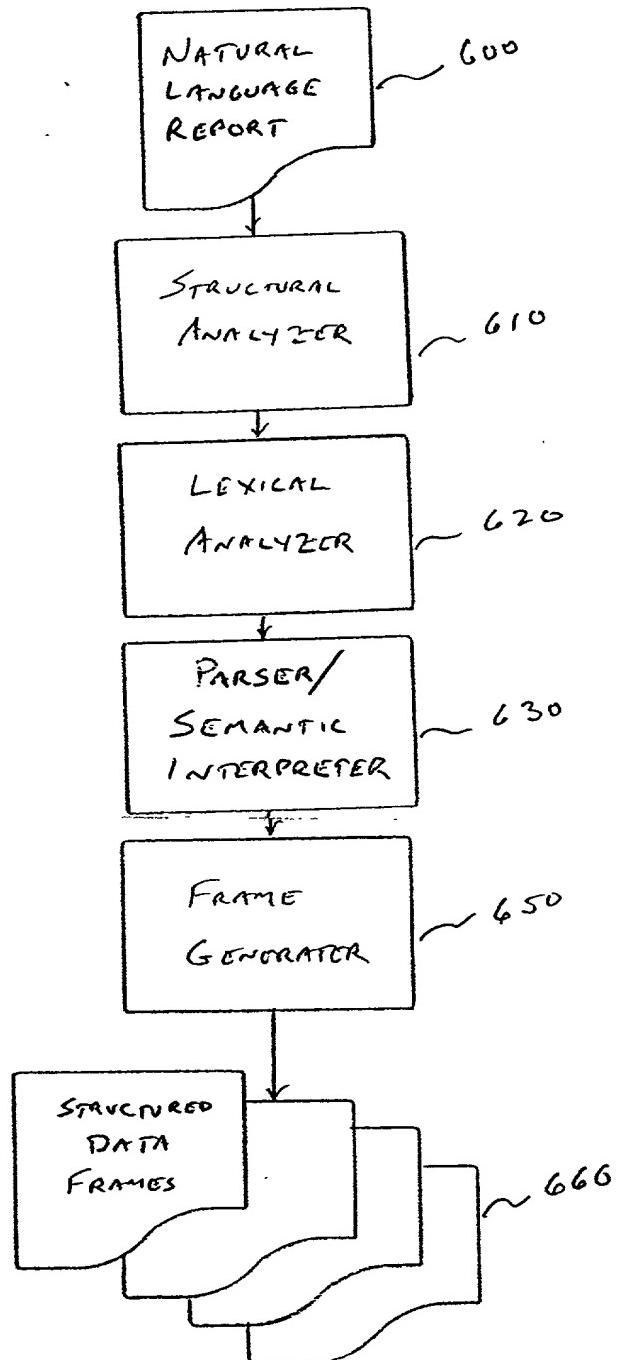


FIGURE 6

Figure 7 - Flowchart for Lexical Analyzer algorithm

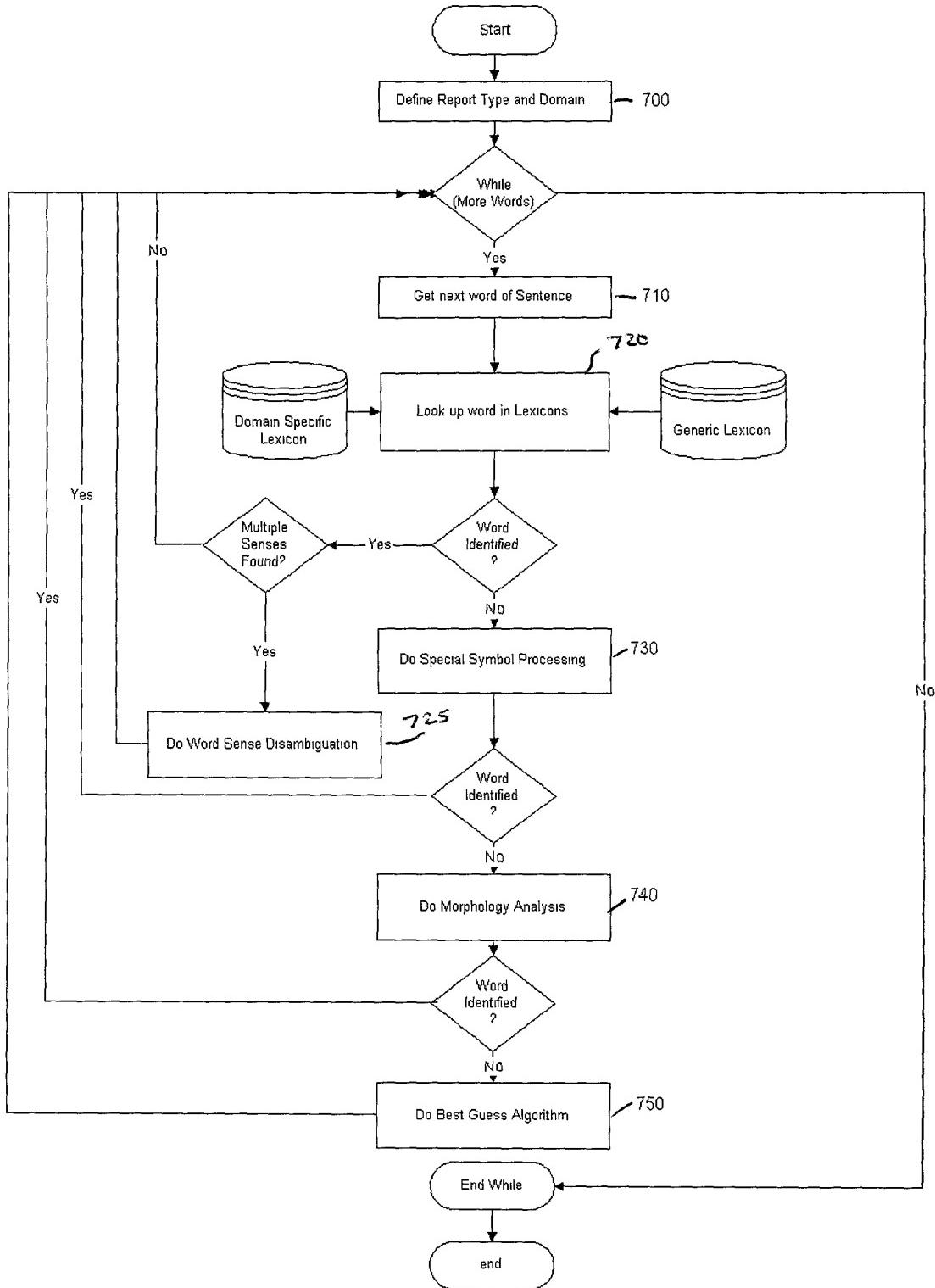


Figure 8 - Method for lexicon construction.

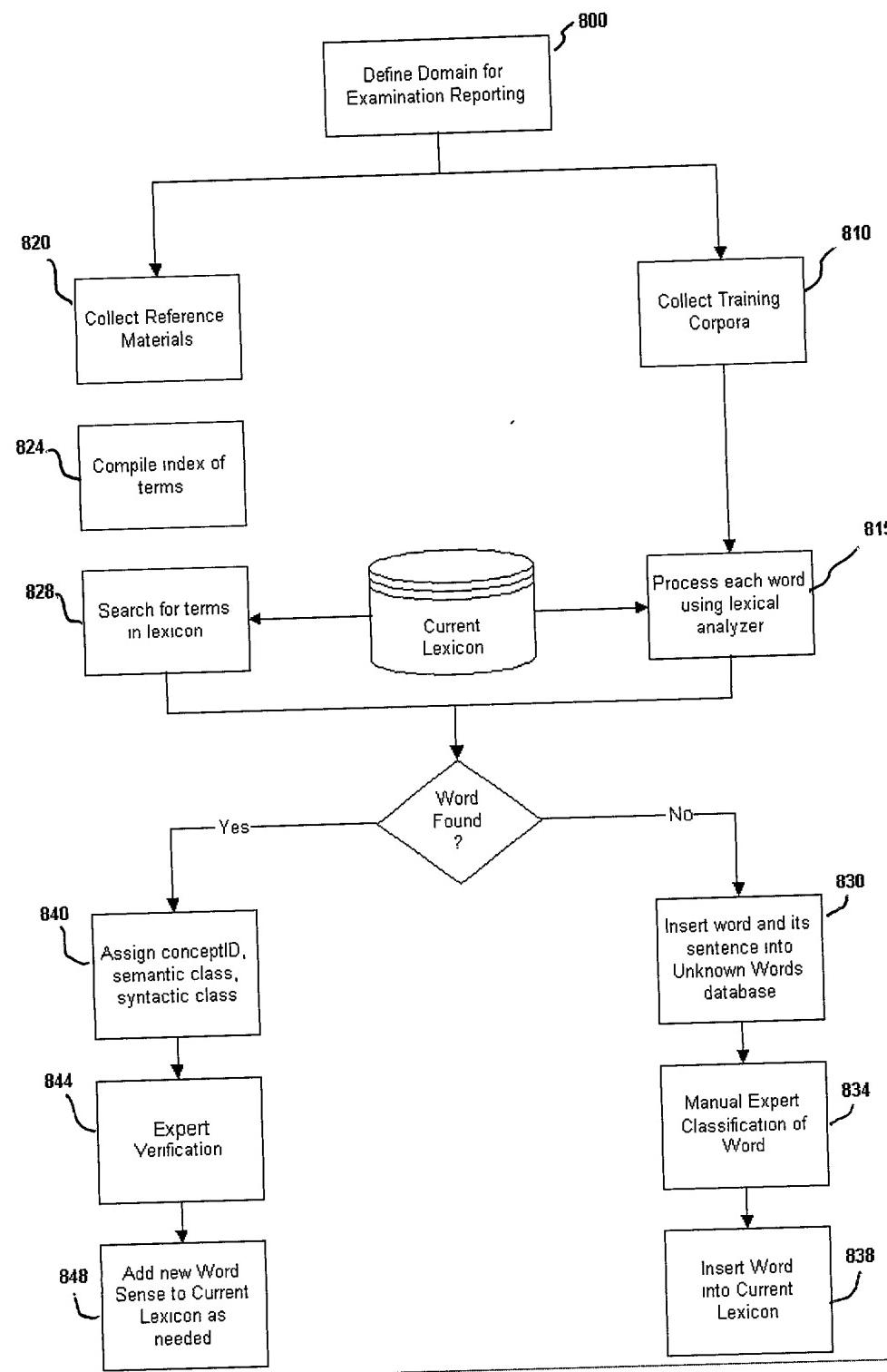


Figure 9A - Dependency diagram for sample sentence illustrating word-word linkages.

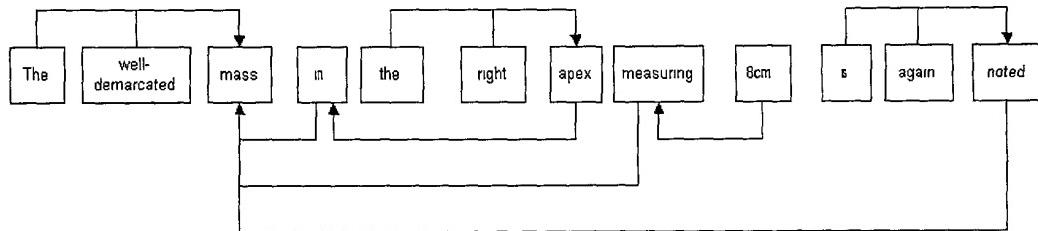


Figure 9B - Set of logical relations extracted from examples sentence in Figure 9a.

predicate	head	relation	value
hasArticle	mass	EQUALS	the
hasBorderDef	mass	EQUALS	well-demarcated
hasLocation	mass	in	apex
hasDirection	apex	EQUALS	right
hasSize	mass	measuring	8cm
hasTempMod	noted	EQUALS	again
hasAuxiliary	noted	EQUALS	is
hasExistence	mass	EQUALS	noted

Figure 10A - Input / output characteristics of logical relation classifier

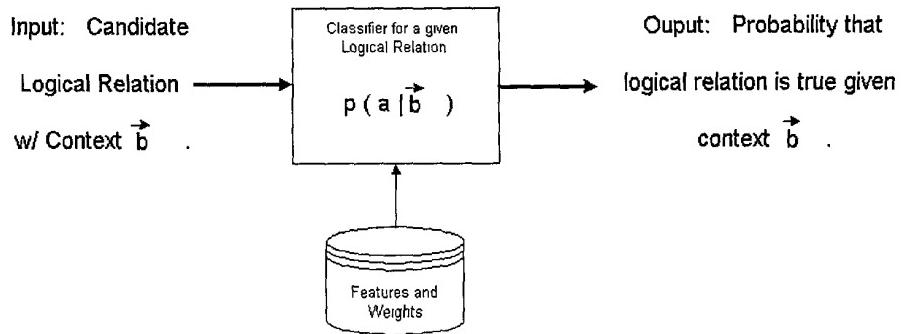


Figure 10B - Functional form of the probability distribution model.

Maximum Entropy Model used for parser / Semantic Interpreter

$$p(a | b) = \frac{1}{Z(b)} \exp \sum_{i=1}^n f_i(a, b)$$

f_i = weighting factor for feature i (Computed from training example statistics)

$Z(b)$ = normalization factor to assure that the probability is within the range 0.0 to 1.0

Figure 10C- Definition of a binary-valued feature function to support (i) positive evidence and (ii) negative evidence

$$(i) \quad f(a, b) = \begin{cases} 1 & \text{if } (a_1 = 1) \& b_2 = \text{true} \& b_6 = \text{true} \& b_8 = \text{false} \\ 0 & \text{otherwise} \end{cases}$$

$$(ii) \quad f(a, b) = \begin{cases} 1 & \text{if } (a_0 = 0) \& b_2 = \text{false} \& b_7 = \text{true} \& b_8 = \text{true} \\ 0 & \text{otherwise} \end{cases}$$

Figure 11A - Solution space for the example sentence:

"The osseus and soft tissue structures of the thorax demonstrate change"

	The	osseus	and	soft tissue	structures	of	thorax	demonstrate	change
The	○			●	●		●	●	●
osseus		○	●	● R	●	●		●	● R
and			○	●	● R				
soft tissue					○	●	●	●	● R
structures						○			
of						●	○		
thorax							● R	○	
demonstrate					●	●	●	○	● R
change							● R	○	○

Figure 11B - Link probabilities of specific word-word interactions. Note that probabilities shown are for illustrative purposes only.

	The	osseus	and	soft tissue	structures	of	thorax	demonstrate	change
The				0.42	0.89		0.13		0.05
osseus				0.78		0.74			0.28
and					0.78			0.31	
soft tissue						0.91		0.42	0.31
structures							0.95		
of								0.95	
thorax									0.92
demonstrate					0.68	0.78		0.65	
change							0.29		

Figure 12: Dealing with Sparse Statistics.

Concept relaxation using type abstraction hierarchies

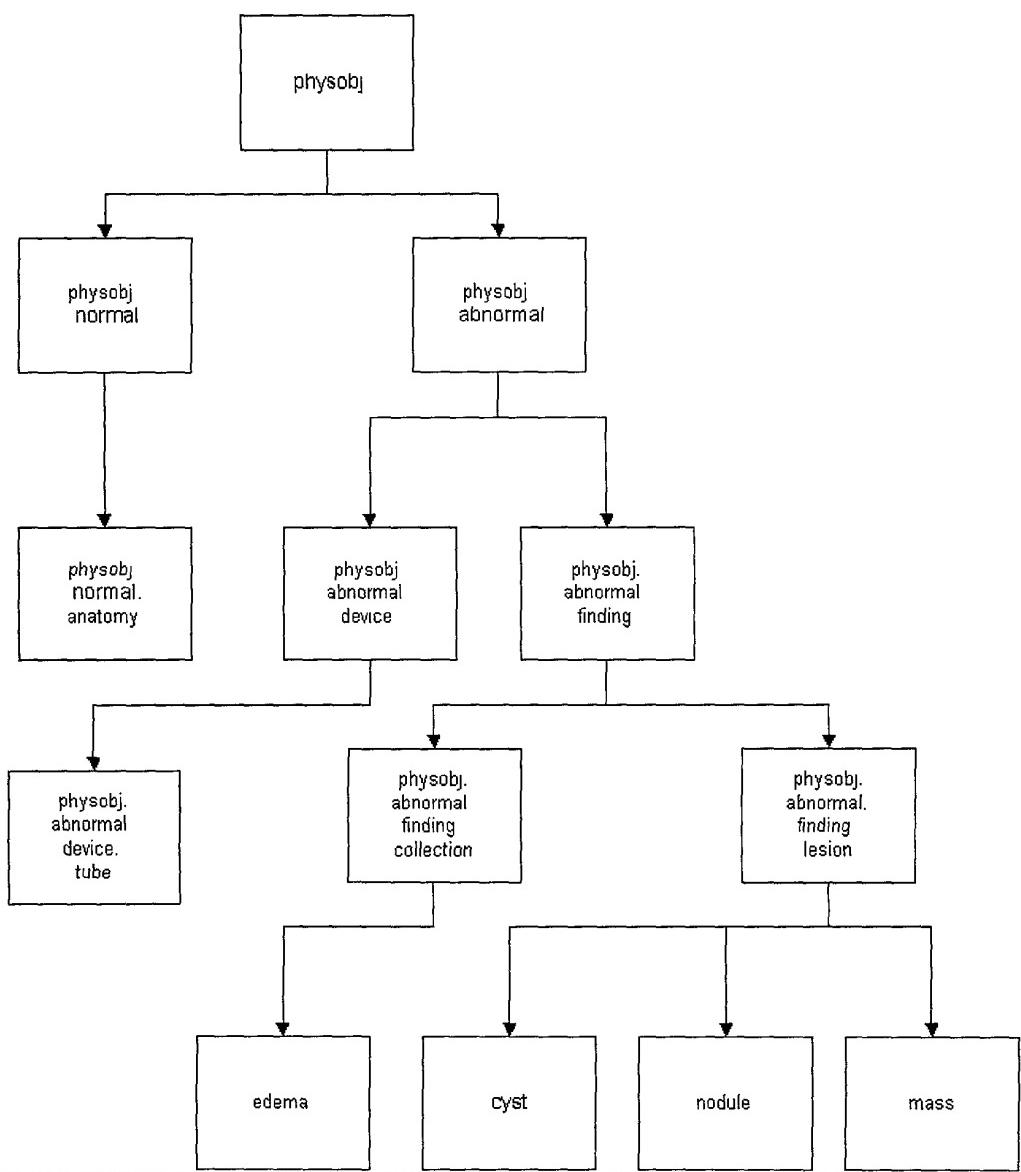


Figure 13 - Parser / Semantic Interpreter Flowchart

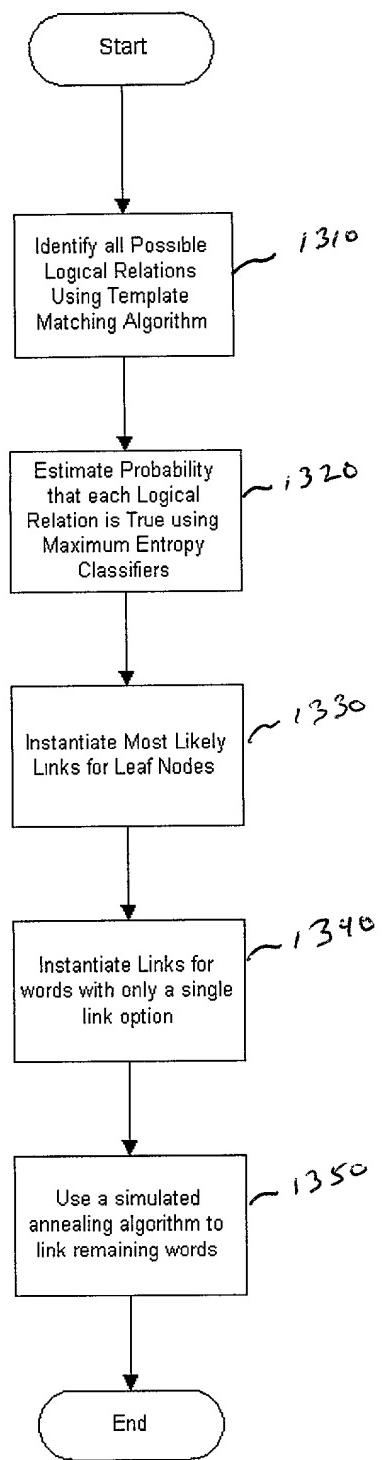
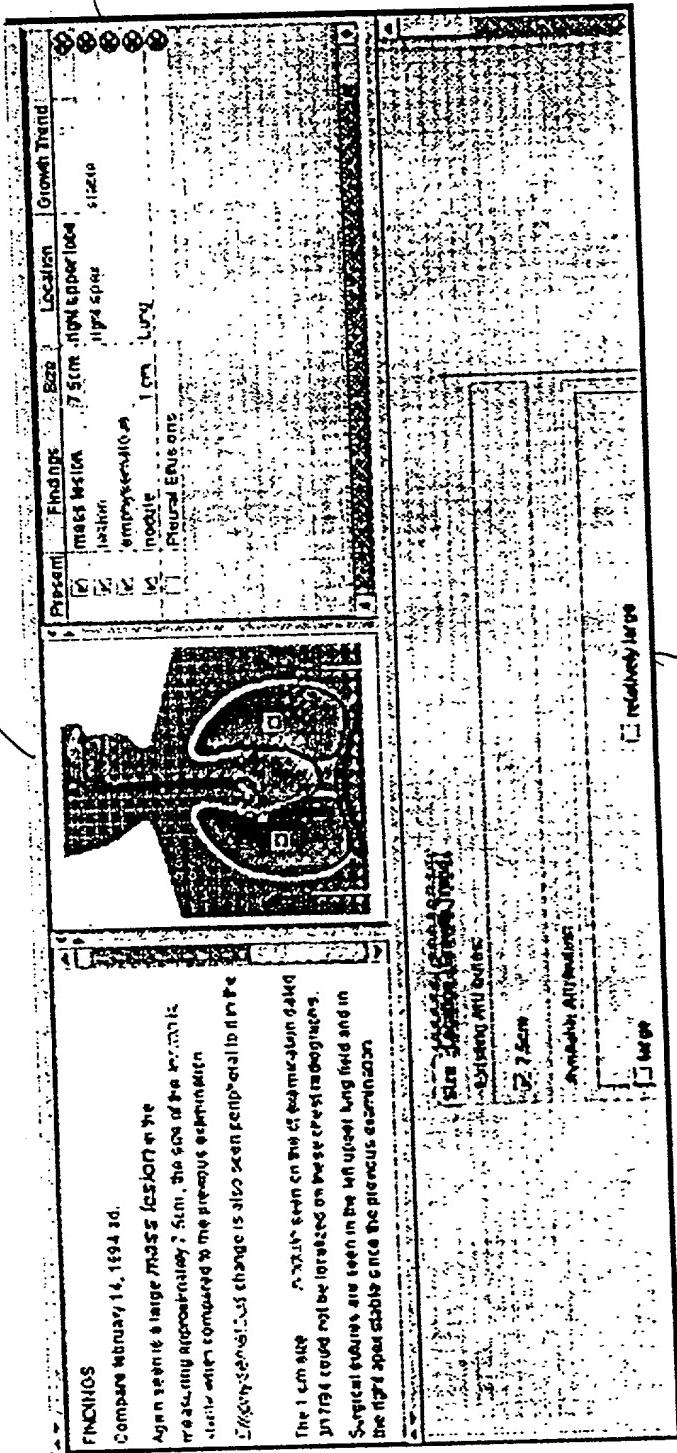


Figure 14



1410

1490

1420

Figure 15 - Output of Frame Generator for example in Figure 9a.

NLP Finding

Entity ID	'mass'										
Entity Class	FINDING Abnormal.lesion										
Existence											
Currently											
<table border="1"> <thead> <tr> <th>Attribute</th> <th>Value</th> </tr> </thead> <tbody> <tr> <td>How Determined</td> <td>by observation</td> </tr> <tr> <td>Certainty of Existence</td> <td>certain</td> </tr> <tr> <td>Relevancy of Note</td> <td>significant</td> </tr> </tbody> </table>		Attribute	Value	How Determined	by observation	Certainty of Existence	certain	Relevancy of Note	significant		
Attribute	Value										
How Determined	by observation										
Certainty of Existence	certain										
Relevancy of Note	significant										
Change (t2=Currently, t1=previous exam)											
<table border="1"> <thead> <tr> <th>Attribute</th> <th>Value</th> </tr> </thead> <tbody> <tr> <td>Direction of Change</td> <td>stable, still exists</td> </tr> <tr> <td>Magnitude of Change</td> <td>no change in existence</td> </tr> </tbody> </table>		Attribute	Value	Direction of Change	stable, still exists	Magnitude of Change	no change in existence				
Attribute	Value										
Direction of Change	stable, still exists										
Magnitude of Change	no change in existence										
Location											
Spatial Relation	Anatomy Description	Standardized Anatomy Description									
'in'	right apex	apex of right upper lobe of lung									
State											
Current											
Size											
<table border="1"> <thead> <tr> <th>Dimension</th> <th>Relation</th> <th>Value</th> <th>Units</th> <th>Precision</th> </tr> </thead> <tbody> <tr> <td>Diameter</td> <td>=</td> <td>8</td> <td>cm</td> <td>approximately</td> </tr> </tbody> </table>		Dimension	Relation	Value	Units	Precision	Diameter	=	8	cm	approximately
Dimension	Relation	Value	Units	Precision							
Diameter	=	8	cm	approximately							
external Architecture											
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Dimension	Relation	Value	Units	Precision							
border definition	=	well demarcated	n/a	n/a							